Complaint/Concern about a Retailer/Farmer

Clinic Name: _____ Staff Name:_____

Retailer/Farmer Name: _____ ID #:_____

Address: _____ City: _____

Date of Occurrence: _____ Approximate Time of Day: _____

Nature of Complaint (Describe fully what was observed):

_____

_____

_____

_____

_____

Description of Cashier and other persons involved. Include names if known, and/or physical description (race, weight, height, age, etc.)

_____

_____

_____

_____

Who is reporting the problem? (check only one)

Participant _____ Local Agency _____

Another Retailer/Farmer _____ Other _____

(list name) (specify)

My name may _____ or may not _____ be given to anyone in connection with this report.

_____

Signature of person filing complaint/concern

(This section to be completed by official Local WIC Staff only)

Person taking complaint/concern report: _____

Date report taken:_____

Follow up action taken:

_____

_____

_____

_____

_____

Who did the follow up? _____

Date follow up completed: _____

Signature: _____ Date: _____

Please send originals to: Montana WIC Program
Retail Services
Dept. of Public Health & Human Services
PO Box 202951
Helena MT 59620-2951

(keep copy in retailer/farmer file)